

FILED DEC 13 1944

State File No. ....

Registration District No. 23944

Primary Registration District No. 3048

Registrar's No. 185-

1. PLACE OF DEATH:

(a) County Madaway

(b) City or town Marionville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution about 1 1/2 day  
(Specify whether years, months or days)

In this community about 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madaway

(c) City or town Marionville 194  
(If outside city or town limits, write "RURAL")

(d) Street No. 816 South Mulberry  
(If rural, give location)

(e) Citizen of foreign country? 11 (Yes or No)  
If yes, name country 11

3. (a) PRINT FULL NAME THOMAS COXWIN COIL

3. (b) If veteran, name war --- 3. (c) Social Security No. ---

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Callie Lulu Coil 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Aug - 2 - 1867  
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 20 If less than one day hr. min.

9. Birthplace Fayette Co. Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business ---

MOTHER FATHER { 12. Name Unknown 9

13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 9

15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Callie Coil

(b) Address 816 S. Mulberry Marionville Mo

17. (a) Burial (b) Date thereof 11-26-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spencerville, Ohio

18. (a) Signature of funeral director Campbell Funeral Home

(b) Address Marionville Mo.

19. (a) Nov. 24 44 (b) Quay Barber  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 22  
year 1944 hour --- minute 5:45 P.M.

21. I hereby certify that I attended the deceased from Nov. 14 - 44  
1944 to Nov 22 1944  
that I last saw h. L alive on Nov 22 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Degeneration

Due to ---

Due to ---

Other conditions 93d  
(Include pregnancy within 3 months of death)

Major findings: ---

Of operations ---

Of autopsy ---

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ---

(b) Date of occurrence ---

(c) Where did injury occur? (City or town) (County) (State) ---

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ---

While at work? (Specify type of place) (c) Means of injury ---

23. Signature M. M. Hallis (M. D. or other) ---

Address Marionville Mo Date signed 11-24-44

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

4  
1  
2

DEC 18 1944

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *William Campbell*.....  
Licensed Embalmer No..... *2620*.....  
P. O. Address..... *Marquette Mo.*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**